

SECTION 1. Company Information:

Company Name		
Street/Mailing Address		
City	ZIP	County
Company Contact Person		Title
Phone	Ext	FAX
Email	Website	Years in Business
Date of Inception	Total FT employees at this location	
Legal Structure of Business	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Non-Profit
	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
Employer's Federal ID #	TN Sales Tax ID #	
Unemployment Insurance ID #	Primary NAICS Codes	
Is your company current on all Tennessee tax obligations?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Total amount your company will spend on training in 2003/2004 (est.) \$_____		
Is your company receiving/applying for other public training funds?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain		
Description of your business, product(s), and/or service(s)		
Amount of Grant Request:	Number of FT Employees to be Trained	
Training Starts (no earlier than 07/01/03) / / Training Ends (no later than 06/30/04) / /		
Local Workforce Investment Area (LWIA):	Contact Name:	Tel:
This company is minority owned. Please Check appropriate box(es)		
<input type="checkbox"/> Native American	<input type="checkbox"/> African American	
<input type="checkbox"/> Asian/American	<input type="checkbox"/> Women-owned	
<input type="checkbox"/> Hispanic American	<input type="checkbox"/> Other minority owned (specify)	

SECTION 2. Training Provider Information:

The Training Provider(s) will be	<input type="checkbox"/> Public training inst.	<input type="checkbox"/> Private training inst.
	<input type="checkbox"/> Company employee	<input type="checkbox"/> Private Instructor
Training will be delivered:	<input type="checkbox"/> On-site	<input type="checkbox"/> At the training institution <input type="checkbox"/> Remote site
Name of Training Provider(s):		
Contact Name:	Phone: ()	
Address:		
City:	State:	ZIP:

SECTION 3. Training Project Information:

Description of the proposed training project:

Number of trainees

- Trainees' Name
- SSN
- Date of Hire
- Job titles
- Departments

Please separate the description by:

- Type of training
- Number of hours of training
- Training provider
- Cost of instruction/tuition
- Any resulting certifications, etc.

Examples:

1. 2) Plastics Operators
 Production Department
 Injection Molding Skills – 28 contact hours each
 Training Provider: Society of Plastics Industry via satellite down link at company site
 \$500 per Trainee
 National Certification in Plastics – NCP Certified Operator
 John Doe, 123-45-6789, Date of Hire: 12/31/00
 Jane Smith, 987-65-4321, Date of Hire: 06/22/01

2. (10) Managers
 Production, Quality Assurance and Accounting Departments
 New Vision Tracking Software for Manufactures
 Training Provider: Company Employee
 (4) Sessions, 6 hours each = 24 hours
 No Certification

 (List name, SSN, Date of Hire of each manager)

SECTION 4. Training Program Budget

Please use this as a guide. Show all formulas used to calculate totals as indicated. BE SPECIFIC

Note: Training funds cannot be used to reimburse any training costs incurred before the grant is approved. Please take this into account when developing your budget and timeline.

A. Budget Category	B. IWT Assistance Requested	C. *Employer Contribution	D. TOTAL (B & C)
1. Instructor Wages/Tuition <i>(This information should reconcile with Section 3. Training Project Description)</i> <i>Example:</i> 1) <i>Injection Molding \$500 X (5) = \$ 2,500</i> 2) <i>New Visions \$25/hr X 24 hours = \$ 600</i> <i>Subtotal = \$ 3,100</i>			
2. Curriculum Development			
3. Materials/Supplies Textbooks (itemize) <i>Example:</i> <i>(10) New Vision Manuals @ \$30 each = \$ 300</i>			
4. Training Equipment Purchase (must be employer contribution)	<i>Cannot fund with IWT grant</i>		
5. Other Costs (describe)			
6. Travel, Food Lodging	<i>Cannot fund with IWT grant</i>		
7. Trainee Wages (including benefits)	<i>Cannot fund with IWT grant</i>		
8. Sub Total			
9. Indirect Costs			
10. TOTALS			

IWT Cost per Trainee

(Line 10 Column B divided by Number of Trainee) =

Employer Contribution Ration

(Line 10 Column C divided by Line 10 Column B) =

Note: The employer must contribute to the training project to receive an IWT grant award. Examples of employer contribution include, but are not limited to expenses association with: Instruction/tuition; curriculum development; materials/supplies; the use of space and equipment during the training project (please show calculation used to assign a value); and trainee wages (including benefits) of employees during training

SECTION 5. Anticipated Outcomes of the Training Project

Please check the boxes that apply to the anticipated outcomes of the proposed training project. **Attach a brief statement to this application for each checked box explaining “how” and/or “why” this training would result in the specific outcome.**

	Will save _____ jobs in our company		Will create _____ openings in entry level positions
	Will improve the long-term wage level of trainees		Will improve the short-term wage levels of trainees
	Will create _____ new jobs within our company		Would help prevent company from having to relocate operations
	Will lower employee turnover in our company		Critical to the long-term viability of our company
	Will assist in the training of veterans		Will make this location more competitive within company
	Will assist in the training of the disabled		Will assist in the training of minorities
	Will increase the profitability of our company		Will assist welfare to work participants
	Will be an important component of our company's overall workforce employee development efforts		Important to the stated mission of our company
	Will assist in the improvement of international trade opportunities		

SECTION 6. Certification by Authorized Company Representative

[Note: The individual signing the application below must have the authority to enter into contracts on behalf of the applying company.]

As an authorized representative of the company listed above, I hereby certify that the information listed above and attached to this application is true and accurate. I am aware that any false information or intended omissions may subject me to civil or criminal penalties for filing of false public records and/or forfeiture of any training award approved through this program.

<i>Signature</i>	<i>Title</i>
<i>Print Name</i>	<i>Date</i>

PLEASE ALLOW AT LEAST 15 BUSINESS DAYS FOR YOUR APPLICATION TO BE PROCESSED

Mail original and three (3) copies to:

Melinda Williams

Director, Employer Services

Tennessee Department of Labor & Workforce Development

Davy Crockett Tower, 12th Floor

500 James Robertson Parkway

Nashville, TN 37245-0658

How did you learn about the Tennessee Incumbent Worker Training Program?